

STANDARD CERTIFICATE OF DEATH

State File No. **35553**

17-39
X21-492

MAILED NOV 15 1940
11

Registration District No. _____

Primary Registration District No. **2002**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Speeman Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Mrs Dora A. Rice

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 23 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Wor Esque Ark. (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Mr Samuel Burke
13. Birthplace Texas
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Luzga Blackburn
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Family

(b) Address Rogers, Ark.

17. (a) Removal (b) Date thereof 9-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rogers ark.

18. (a) Signature of funeral director William Frank Howard

(b) Address Rogers ark.

19. (a) 10-12-40 (b) W D Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ark. (b) County Benton
(c) City or town Rogers (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24 - 1940
year 1940 hour 10 minute 40 P. M.

21. I hereby certify that I attended the deceased from June 29
1940 to Sept 24 1940

that I last saw her alive on Sept. 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Renal
Auto Renal Suppression

Due to Nephrectomy

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Nephrectomy

Of autopsy No.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? 372 (Specify type of place) (Specify means of injury)

23. Signature W D Jones (M. D. or other) M.P.
Address Joplin Date signed 10-14-40

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1222

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____ working under my personal supervision.

Signed _____

_____ Licensed Embalmer No. _____

_____ P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35-5-3**

DEPARTMENT OF COMMERCE
- BUREAU OF THE CENSUS

Registration District No. **411**

Primary Registration District No. **2002**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Jasper**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME **Mrs. Nora A. Rice**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **65** Months **11** Days **29** If less than one day _____ hr. _____ min.

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **Sept** day **24**
year **1970** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death **acute Renal Depression**

Due to **Nephrectomy**

Due to **Glomerulonephritis**

Other conditions _____

(Include pregnancy within 3 months of death) **133A**

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTAL

